NICE®
Non Invasive
Chromosome Examination

Test Requisition Form

PATIENT INFORMATION

First Name _____ Last Name _____

DOB (dd/mm/yy) _____ Weight _____ lb/kg Height _____ cm

ID / Passport # _____ Address _____

ACCOUNT / ORDERING PHYSICIAN / PROVIDER

Physician / First Name _____ Last Name _____

Hospital / Clinic _____

Address _____

Email _____ Phone _____ Fax _____

TEST INFORMATION

☐ Singleton (available for GA 10 weeks or more)
- ☐ NICE® Lite - Chromosomes 21, 18, 13
- ☐ NICE® - Chromosomes 21, 18, 13, 9, 16, 22 + Sex chr. + Fetal sex

☐ Twin (available for GA 12 weeks or more)
- ☐ NICE® - chromosomes 21, 18, 13 + Y chr.

TEST INDICATIONS

☐ Advanced maternal age
☐ Positive serum screen
☐ Abnormal ultrasound
☐ History of pregnancy with T21, T18, T13, MX, or other sex chromosome aneuploidy

CLINICAL INFORMATION

Gestational age _____ Wks _____ Days

Dating method ☐ CRL ☐ LMP ☐ Date of implantation ☐ Other Date of draw (dd/mm/yy) _____

Specimen type Blood 8-10mL (with NICE® tube)

Comments _____

PATIENT CONSENT

By signing this form, I voluntarily request that EDGC perform the NICE® prenatal test. I have read and have received a copy of the patient consent included below from my provider. The risks, benefits, and limitations of this test have been adequately explained to me.

Date (dd/mm/yy): _____

Patient Name: _____ (signature)

PHYSICIAN CONSENT

I verify that the patient and prescriber information in this form is complete and accurate to the best of my knowledge and that I have ordered the NICE® prenatal test based on my professional judgment of medical necessity. I have addressed the limitations of this test, and have answered any question to the best of my ability.

Date (dd/mm/yy): _____

Physician Name: _____ (signature)

BRIA

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